May 23, 2013

Recommendations of the Working Group on Financial Sustainability to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Financial Sustainability Working Group, chaired by Leighton Ku and Jill Thorpe (Vice Chair). Its purpose is to recommend sources of funding for the operating costs of the Exchange after federal funds have expired by; recommendations should be by consensus or, if consensus is not possible, to summarize alternatives and the arguments for and against positions on which the working group could not achieve consensus.

The working group unanimously recommends the following: the Health Benefit Exchange (HBX) staff will assess the extent to which the existing 2% premium tax and/or .3% Department of Insurance, Securities and Banking (DISB) operating assessment can support the Exchange. If it is not possible to use the existing revenue sources or if additional revenue is required, they should be raised from an assessment on all health insurance premiums written in the District. If feasible, this should include assessments on reinsurance or stop loss premiums.

Background

Federal grant funding is largely financing Exchange implementation costs through the end of 2014. The Exchange is required to be financially self-sustainable beginning in 2015. A wide range of revenue sources can finance Exchange operations, from a "user fee" placed on Exchange enrollment to broader sources such as general tax revenue. While federal funding should sustain operations until the beginning of 2015, it was recognized that it will be necessary to begin revenue collection before then, in order to ensure that there is a reserve of working funds for Exchange operations at the beginning of 2015.

The Board asked the working group to review and discuss potential Exchange revenue sources and make a recommendation as to which source(s) of revenue the Exchange should use to support its operations. The working group determined that the scope of its recommendation should not define an exact percentage or dollar figure since reasonable operating expenses are still being projected.

The working group was very well attended. About 15 people in person and on the phone attended all three meetings. A recommendation was developed in the third meeting which garnered unanimous support.

Working Group Discussion

Wakely Consulting Group ("Wakely") facilitated the working group's meetings and provided the group with background paper, which included examples of potential revenue sources and criteria to evaluate those sources (See Appendix B). The working group developed the following list of criteria to evaluate potential revenue sources:

1. **Exchange Value Relationship** – how closely is the assessment tied to the value the Exchange provides?
2. **Administrative Ease** – how difficult or administratively costly is the revenue model to the Exchange?
3. **Complexity and Variability of Revenue Source** – how stable or predictable is the expected revenue stream? If it is necessary to change or alter the revenue source, what is the process and necessary lead time?
4. **Burden** – does the assessment cause undue burden to small businesses or low income individuals?
5. **Market Impacts** – what incentives or market impacts are caused by the assessment?
6. **Political Feasibility** – how politically or legislatively feasible is the assessment?

The working group then discussed a wide range of potential revenue sources, which included:

- Qualified Health Plan (QHP) Enrollment – user fee (or surcharge) on premiums administered through the Exchange
- All Insured Premiums – assessment on insurance premium revenue (individual, small group, and large group markets)
- Health Care Market – assessment on all benefits, including self-insured plans, or hospital revenue and other private medical claims as a way to reach all medical benefits
- Public Funding Source – e.g. tobacco tax, soda tax, or general tax revenues

There seemed to be general agreement that an assessment on hospital revenues or a public funding source could have legal problems and/or politically infeasible, and therefore it was determined that the working group should not consider these revenue sources in its recommendation to the Board. The group then defined three revenue source options to consider:

1. Assessment on Exchange Enrollment Only (user fee)
2. Assessment on Non-group and Small Group Markets
3. Assessment on Health Insurance Market – Similar to the Insurance Premium Tax (Non-group & Small Group & Large Group & Medicaid Managed Care Organization (MCO))

Wakely developed estimates for the levels of assessments necessary to meet Exchange operating costs, for each of the revenue source options. (These are net of federal grants, which cease after 2014.)

Exchange staff suggested the working group evaluate revenue source options based on the assumption that the Exchange's annual operating costs will be between $20 – 25 million for the years 2014 to 2016. This assumption aligns with current estimates for Exchange operating expenses, but a more precise Exchange operating budget has not yet been determined. Phil Barlow of DISB also spoke with the group about the Insurance Premium Tax and the DISB assessment and provided Wakely with support in conducting its analysis. Please see Appendix C for details on the analysis and estimates for each of the three revenue sources options.

During the second meeting, representatives of CareFirst, Kaiser and MedStar noted some concerns about all three options, but were not prepared to take a position or offer an alternative at that time. Dr. Ku asked all members of the working group to be prepared to vote in the third session and asked people to forward any alternatives to the group before the final session. In response, Randy Sergent of CareFirst submitted comments (attached in Appendix E), expressing the view that it would be better if taxes or assessments were not raised, but funded out of existing revenues, such as the current health insurance tax and assessments. He noted that Maryland anticipates funding their exchange using the existing revenue sources. There may be unanticipated growth in these revenues because of the combination of more policies sold through the Exchange and premium increases related to Affordable Care Act (ACA) implementation.

Recommendation to the Board

At the third meeting, Dr. Ku proposed a compromise, described below, which was unanimously accepted by the working group.

Recommendation: To the extent that it is feasible to use the existing 2% premium tax and/or .3% DISB operating assessment to support the Exchange, these revenues should be used. If this is not feasible or if additional funds are needed, a broad-based assessment on all health insurance premiums is the preferred revenue source. Specifically:

1. HBX staff should, in consultation with other District officials, determine if there will be unanticipated collections from the existing health insurance tax and assessments that can be used to support the Exchange Authority and that this is consistent with the legislative requirement that the Authority be "financially self-sustaining."[1]
2. If this is not feasible, or if additional revenues are needed, the preferred source of revenue is a broad-based assessment of health insurance premiums, including Non-group, Small Group, Large Group and Medicaid MCO premiums, written in the District.
3. If feasible and cost-effective, this should also include assessments on reinsurance and stop-loss insurance policies.

[1] One member supported the general approach, but felt that a higher level of current health insurance premium taxes or assessments could be devoted to the HBX and that a fixed percentage should be dedicated to that approach. However, two other committee members did not agree with that modification. Please see statements #2,3,4 in Appendix E for the initial member's suggested change in language and the two members' subsequent disagreement.

If this recommendation is accepted by the Executive Board, HBX staff should report back to the Board on its findings and the plan for future sources of revenue for the Exchange Authority.

Commentary:

While evaluating criteria, there seemed to be unanimous consensus among working group members that the Exchange should pursue a broad revenue source. Wakely's analysis and estimates supported this notion. A relatively large assessment would need to be placed on the market for options 1 and 2, to support Exchange operations. On the other hand, option 3 assesses a larger base and would require a lower percentage assessment on the market. Based on the analysis, if the Exchange's operating costs are $22.5 million (the "middle" scenario) when the unitary market is fully phased in (2016), a 0.70% assessment would need to be placed on option 3 to be financially sustainable.

The CareFirst representative favored re-purposing existing premium taxes instead of adding to them. Other members noted that there may be other budget plans for the existing revenues (so that, for example, shifting some revenue to the Exchange might cause a loss for another effort) or that this might not be consistent with the idea that the Exchange be self-sustaining. The CareFirst representative also raised the concern that an increase in the Insurance Premium Tax may trigger retaliatory taxes from Maryland and/or Virginia. To reach consensus, members voted with the understanding that Exchange staff will first determine if using the existing assessment is feasible without raising the premium tax rate.

Several working group members were also interested in including the reinsurance and stop loss markets in the broad based assessment of option 3. Wakely performed high level estimates on this issue and determined that including reinsurance in the assessment would only provide minimal additional revenue to the Exchange (the 0.70% assessment for 2016 described above would decrease to 0.69%). Discussions with DISB also revealed that in their opinion the reinsurance markets will be administratively difficult to assess and doing so may encourage these premiums to be written outside of the District. To meet the interests of all working group members, the recommendation to the Board includes the understanding that Exchange staff will determine if it (or DISB) has the authority and ability to include these additional insurance markets in its assessment and whether it is feasible or cost-effective to make such an assessment.

In addition, the group also discussed the fact that increases in enrollment and premium levels, due to the Affordable Care Act (ACA), will increase premium tax revenues compared to levels prior to ACA implementation. While Wakely has estimated that the increase in premium tax revenues due to the ACA will be relatively modest ($1.6 million in 2015 at the 2% premium tax rate), this concept should be taken into consideration when determining if premium tax revenue can be re-purposed for the Exchange.

Working group members were invited to submit a short statement clarifying their position. These statements are attached in Appendix E. Also please see attached appendices for more details on discussions of the working group and revenue source option estimates.

Appendix A: Working Group Members

The following list of the DC HBX Financial Sustainability Working Group Members is a list of those members present during the final meeting, when the recommendation vote was taken. Additional members may be absent from this list.

DC HBX Financial Sustainability Working Group Members participating in the final recommendation:

Member Name	Affiliation
Susan Walker	Consumer Advocate
Bill Simmons	Group Benefit Services
Diane Marcus	Insurance Broker
Laurie Kuiper	Kaiser Permanente
Randy Sergent	CareFirst
Deborah Chollet	Mathematica Policy Research
Regina Woods	MedStar
Katherine Stocks	Goldblatt Martin Pozen
Dave Chandra	Center on Budget and Policy Priorities
Justin Palmer	(Not Listed)
Wes Rivers	DC Fiscal Policy Institute
Matthew Grace	First Financial Group

Leighton Ku (Chair), Executive Board member
Jill Thorpe (Co-chair), Advisory Board member

Appendix B: Background Analysis

Draft, for policy discussion

Background Analysis

DCHBX Financial Sustainability Working Group

Summary

The following report provides the DCHBX Financial Sustainability Working Group with background information regarding options for generating operating revenue for the DCHBX, which will facilitate discussion and assist the working group in fulfilling its charge. First, potential Exchange revenue options are presented and then criteria are discussed to evaluate these options.

The working group's charge is to evaluate and recommend revenue sources to the Board of Directors. For purposes of assessing revenue options, we can assume an annual operating budget for the DCHBX of approximately $25 million.

Revenue Options

Although there are a number of potential financing methodologies that could support Exchange operations, for ease of discussion we have grouped the most common into the four broad categories: (1) a user fee applied to Exchange enrollees; (2) revenue models focused on all health insurance premiums in the District; (3) revenue models focused on the broader health care market (e.g., all insurers and/or hospital and physician revenue); and (4) broad taxes or general revenues. Examples of these revenue models are highlighted in the table below.

Revenue Type	Examples of Specific Revenue Bases
QHP enrollment	User fee (or surcharge) on Exchange enrollees
All Insured Premiums	
	Insurance Premium Revenue Assessment (individual, small group and large group market segments)
Health Care Market	
	Hospital Revenue Assessment
	Other Provider Revenue Assessment
Public Funding Source	Ex. Tobacco Tax, Soda Tax, etc.
	General Tax Funds - Other Broad-based Revenue Source

QHP Issuer-based Revenue Models - A QHP issuer-based assessment would involve charging a fee to issuers of QHPs, most likely based upon a percent of premium or a flat per-member per-month (PMPM) amount. There are two types of assessment that can be charged to QHP issuers: one that only applies to Exchange membership and one that applies to the issuer's entire enrollment base. As DC has decided to close the individual and small-group markets outside the Exchange, with a transition period for small employers, an assessment on an issuer's entire QHP enrollment base will apply to the same base as the user fee as of 2016.

Insurance -based Revenue Models – An assessment on total health insurance premiums. This model expands the revenue based from issuers of QHPs to all health insurance companies in the District, and from premiums that flow through the Exchange to all premium revenue, including that associated with large employers who are insured.

Health Care Market-based Revenue Models-- Assessing the revenues associated with the entire market for private coverage means including self-insured employers as well. Because ERISA pre-empts state and local taxation of self-insured employee benefits, to reach this part of the market requires an assessment on claims paid on behalf of self-insured employers to clinical providers. The range of providers that would be assessed range from all acute-care providers to hospital revenues only.

Public Funding Sources – A public funding source as an Exchange revenue model would not be linked specifically to health industry revenue sources, but instead would involve broader public funding to finance the Exchange. Examples of public funding sources include increasing or repurposing a tax on tobacco or general revenues.

Criteria

Although the working group could consider numerous criteria when evaluating potential Exchange revenue sources, this background report summarizes three important exchange operations criteria; (1) Exchange value relationship (2) administrative ease (3) complexity and variability of the revenue source. The table below shows these criteria with questions for the working group to consider for each.

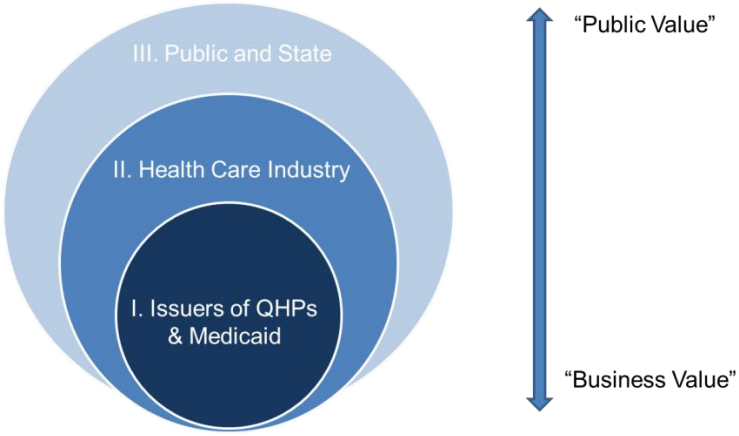
Evaluative Criteria	Questions for Consideration
Exchange Value Relationship	• How closely tied is the Exchange to the assessment? • How valuable (on a relative scale) is the Exchange to the market being assessed? • Does the Exchange perform a specific function(s) on behalf of the market? • Are there efficiencies to be gained through the Exchange?
Administrative Ease	• How difficult or administratively costly is the revenue model to the Exchange? • Can current State/Exchange processes be leveraged to implement the fee?
Complexity and Variability of Revenue Source	• How stable is the expected revenue stream to the Exchange? • Does the predictability change over time? • If necessary to alter or change the fee, what is the process and lead time necessary to change? • Does the revenue stream address exchange cash flow needs?

Exchange Value Relationship

The Affordable Care Act ("ACA") requires that the DCHBX provide a number of different functions and services, which benefit a broad range of markets and populations. Among its required functions, the DCHBX must perform the following:

- Review and certify issuers, health benefit plans, and stand-alone dental plans as Qualified Health Plans ("QHPs");
- Develop and host a web portal to support individual and small employer comparison of health plans and purchase of insurance;
- Determine individual eligibility for and administer the distribution of federal tax credits and subsidies;
- Enroll individuals and small businesses in health insurance coverage;
- Provide customer service support and consumer assistance;
- Oversee and finance a Navigator program;
- Engage in targeted and broad-based marketing to encourage enrollment;
- Provide for the acceptance and adjudication of individual and employer appeals; and
- Provide a host of public reporting on health plan quality and Exchange operations

These required Exchange functions can be viewed as providing both narrowly focused "business value" to certain market players, and broader "public values" to entities and residents of the District. The working group may wish to consider choosing a revenue source based on the value that the Exchange provides to different stakeholder groups. The figure below illustrates three potential levels of Exchange value.



I. Value to Issuers of QHP and Medicaid

QHP Issuers and Medicaid can be considered the Exchange's "business partners", and the Exchange provides direct value to them by performing a number of critical functions, including:

- Eligibility determination and enrollment
- Account installation and management
- Broad-based and targeted marketing
- Front-end communications – collateral material and web-portal hosting
- Customer service and customer assistance
- Ensuring accurate data transmittal for tax credit purposes

The value the Exchange provides by performing these functions is particularly relevant in the small and non-group insurance markets, where administration as a share of total premium cost is highest, due to the high number of transactions for low enrollment yields. Whereas an issuer that closes a single sale in the large group market may yield thousands of new members, it may take that same issuer hundreds of individual sales in the small and non-group market – with all of their associated marketing, account set up, and customer service costs – to yield the same level of membership. The Exchange's role in organizing the market, providing a single web portal, and leveraging its scale efficiencies to perform many of these administrative functions is therefore of particular value to issuers selling small and non-group insurance.

II. Value to the Health Care Market

The Exchange will also provide tangible value to the health care industry as a whole, including both health insurers and health care providers. In addition to offering a path to enrollment for those currently uninsured, the Exchange will capture federal subsidy dollars as well as individual and employer contributions, and distribute these funding streams throughout the health care market. Funds will first be paid to insurers in the form of premium revenue, and next to the provider community as the majority of insurance premium revenue is distributed to pay for medical services. Additional values to the health care market include:

- Facilitate distribution of federal subsidy dollars and individual/employer premium contributions to the health care market;
- Increase coverage of residents and reduce uncompensated care – which is widely viewed as a net positive to the health care market;
- The Exchange expands health insurance coverage, provides a web-portal with decision support tools, and educates consumers, which in theory could save time and money by reducing provider bad debt and other inefficiencies;
- The Exchange will provide information and metrics on cost and quality of health care. This information will be made available to the public and will serve as source of comparative information, which may also encourage providers to improve their quality and efficiency, thus improving the delivery of health services to all.

III. Value to the Public and State (District)

Beyond its direct business relationships and the health care market, the Exchange also provides significant and quantifiable value to the public and the district in the form of expanded coverage, greater security in the ability to access affordable coverage when necessary, positive economic impact, and greater access to health care information. Values that the Exchange may provide to the public and the district also include:

- Offers a destination to purchase affordable coverage and receive Federal tax credits. Provides a form of “un-insurance insurance” as DC residents who lose or are without coverage can purchase insurance that has been approved by the DCHBX;
- Ensures that coverage sold through the Exchange meets Federal standards, including minimum coverage standards and cost-sharing levels;
- Additional economic output;
- Improve physical health of residents; and
- Source of information about health care and insurance, including educating people on plan designs, coinsurance, co-pays, deductibles. Exchange may be a destination site for the general public seeking information on health care reform.

Revenue Source Decisions of Other State-based Exchanges

Many state-based Exchanges are currently completing legislative discussions to determine which revenue methodology best suits their states. Few States have made a final revenue methodology determination. Colorado recently recommended a combination of methodologies including a 1.4% transaction fee on Exchange premiums, a broader assessment on insurers which includes assessing business outside the Exchange, and a state tax credit for Insurers who donate to the Exchange. This decision was partly driven by the fact that state law establishing Colorado's Exchange prohibits using any state tax money to fund its operations.[1] Oregon on the other hand is employing a more narrow assessment applied to exchange premiums only, as did Massachusetts when it began operations in 2006.

Health and Human Services (HHS) which is administering the Federally Facilitated Exchanges (FFE), has announced it will implement a 3.5% assessment on insurers for Exchange premium revenue.[2] The decision to pursue this assessment was likely driven by the fact that the FFE revenue model will be applied to many states, and tax/legal implications for each state could not be taken into consideration. The 3.5% FFE assessment provides a reference point, but may not be relevant for State-based Exchanges.

[1] Whitney, Eric. "Colorado Sets Its Exchange Fee". Colorado Public Radio. March 13, 2013. http://capsules.kaiserhealthnews.org/?p=17737

[2] Kliff, Sarah. "Want to sell insurance on the Obamacare exchanges? There's a (3.5%) fee for that." Washington Post Wonkblog. November 30, 2012. http://www.washingtonpost.com/blogs/wonkblog/wp/2012/11/30/want-to-sell-insurance-on-the-obamacare-exchanges-theres-a-3-5-fee-for-that/

Appendix C: Revenue Source Options Analysis
DC HBX Financial Sustainability Working Group

The following document provides the Financial Sustainability Working Group with an analysis of Exchange revenue source options, which were discussed during the first meeting. Projections used in this analysis should be considered high level estimates and the primary purpose of this analysis is to provide the working group with benchmark values to assist the group in making a recommendation for an Exchange revenue source.

Three revenue source options are considered:

1. Assessment on Exchange Enrollment Only (user fee)
2. Assessment on Non-group and Small Group Markets
3. Assessment on Health Insurance Market Similar to Premium Tax (Non-group & Small Group & Large Group & Medicaid MCO)

It is estimated that annual Exchange operating expenses will be between $20 million and $25 million for the years 2014 to 2016. We considered three scenarios for Exchange operating expenses; Low, Medium, and High with annual operating expenses of $20 million, $22.5 million, and $25 million respectively.

The DC health insurance market will be "closed" to the Exchange, meaning that the Exchange will be the only marketplace for the Non-group and Small Group markets. However, there will be a transition period for the Small Group market, in which the market will not be fully "closed" until the beginning of 2016. The following analysis makes assumptions to account for the "closed" market transition period.

Below is a summary of the assessments necessary for each of the three revenue source options listed above. The following pages of this document provide further detailed calculations and explain how the assessment rates were derived.

Option 1: Assessment on Exchange Enrollment Only

Carriers would be responsible for paying a % fee on premiums administered through the Exchange.

Assessment on Exchange enrollment necessary to meet Exchange operating expenses:

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	12.72%	4.89%	3.14%
Medium	$ 22,500,000	14.32%	5.50%	3.54%
High	$ 25,000,000	15.91%	6.12%	3.93%

Option 2: Assessment on Total Non-group and Small Group Markets

An assessment would be placed on the total Non-group and Small Group premiums written In the DC market. This assessment is similar to the Insurance Premium Tax, but would only be placed on the Non-group and Small Group premiums. Due to the fact that DC will be a "closed" market for Non-group and Small Group, this assessment will be equivalent to option 1 starting in 2016. Due to the transition period, this assessment will be different than option 1 for 2014 and 2015.

Assessment on Non-group and Small Group markets necessary to meet Exchange operating expenses:

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	3.73%	3.42%	3.14%
Medium	$ 22,500,000	4.20%	3.84%	3.54%
High	$ 25,000,000	4.67%	4.27%	3.93%

Option 3: Assessment on Total Health Insurance Market Similar to Premium Tax (Non-group + Small Group + Large Group + Medicaid MCO)

This assessment will be place on the Non-group, Small Group, Large Group, and Medicaid MCO markets, similar to the health portion of the Insurance Premium Tax.

Assessment on health insurance market necessary to meet Exchange operating expenses:

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	0.70%	0.66%	0.62%
Medium	$ 22,500,000	0.79%	0.74%	0.70%
High	$ 25,000,000	0.87%	0.83%	0.78%

Calculations for Revenue Source Analysis for DC HBX Financial Sustainability Working Group (draft for discussion only)

a.) DC Health Insurance Market without ACA

Assumptions

Growth rate assumption due to premium price increase and uniform to all markets
Large group premiums do not include FEHB because FEHB not subject to premium tax
Medicaid MCOs are included because they are subject to premium taxes
Premium levels for 2012 provided by DISB

Total Premiums

	2012	2013	2014	2015	2016
Growth Assumption		5%	5%	5%	5%
Non-Group Premiums	$ 54,821,011	$ 57,562,062	$ 60,440,165	$ 63,462,173	$ 66,635,282
Small Group Premiums	$ 381,397,303	$ 400,467,168	$ 420,490,527	$ 441,515,053	$ 463,590,806
Large Group Premiums	$ 1,525,432,917	$ 1,601,704,563	$ 1,681,789,791	$ 1,765,879,281	$ 1,854,173,245
Medicaid MCO	$ 585,653,086	$ 614,935,740	$ 645,682,527	$ 677,966,654	$ 711,864,986
Total	$ 2,547,304,317	$ 2,674,669,533	$ 2,808,403,009	$ 2,948,823,160	$ 3,096,264,318

Value of Premium Tax

	2014	2015	2016
Premium Tax Revenue @ 2%	$ 56,168,060	$ 58,976,463	$ 61,925,286

b.) DC Health Insurance Market with ACA

Assumptions

Growth rate assumptions include growth due to increase in people covered by insurance and increases in premium prices

Total Premiums

	2013	2014	2015	2016
Non-Group Growth Assumption		100%	25%	20%
Small Group Growth Assumption		5%	5%	5%
Large Group Growth Assumption		5%	5%	5%
Medicaid Growth Assumption		5%	5%	5%
Non-Group Premiums	$ 57,562,062	$ 115,124,123	$ 143,905,154	$ 172,686,185
Small Group Premiums	$ 400,467,168	$ 420,490,527	$ 441,515,053	$ 463,590,806
Large Group Premiums	$ 1,601,704,563	$ 1,681,789,791	$ 1,765,879,281	$ 1,854,173,245
Medicaid MCO	$ 614,935,740	$ 645,682,527	$ 677,966,654	$ 711,864,986
Total	$ 2,674,669,533	$ 2,863,086,968	$ 3,029,266,141	$ 3,202,315,221

Value of Premium Tax

	2014	2015	2016
Premium Tax Revenue @ 2%	$ 57,261,739	$ 60,585,323	$ 64,046,304

c.) Expected Premiums to be Administered Through Exchange

Assumptions

The Exchange will capture all of the Individual market due to closed market
The Exchange will capture 10% of the Small group market in 2014 and 60% in 2015 due to the transition period for the SG market

Total Premiums through Exchange

	2014	2015	2016
Individual	$ 115,124,123	$ 143,905,154	$ 172,686,185
SHOP	$ 42,049,053	$ 264,909,032	$ 463,590,806
Total	$ 157,173,176	$ 408,814,186	$ 636,276,990

d.) Analysis of Change in Premium Tax Revenue due to ACA

Value of Premium Tax without ACA (from section a. above)

	2014	2015	2016
Premium Tax Revenue @ 2%	$ 56,168,060	$ 58,976,463	$ 61,925,286

Value of Premium Tax with ACA (from section b. above)

	2014	2015	2016
Premium Tax Revenue @ 2%	$ 57,261,739	$ 60,585,323	$ 64,046,304

Change in Premium Tax Revenue due to ACA

	2014	2015	2016
Premium Tax Revenue @ 2%	$ 1,093,679	$ 1,608,860	$ 2,121,018

e.) Analysis of Revenue Source Options

Option 1: Assessment on Exchange Enrollment Only

Exchange Premium Base (from section c. above)

	2014	2015	2016
Individual	$ 115,124,123	$ 143,905,154	$ 172,686,185
SHOP	$ 42,049,053	$ 264,909,032	$ 463,590,806
Total	$ 157,173,176	$ 408,814,186	$ 636,276,990

Assessment on Exchange Enrollment Necessary to Meet Exchange Operating Expenses

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	12.72%	4.89%	3.14%
Medium	$ 22,500,000	14.32%	5.50%	3.54%
High	$ 25,000,000	15.91%	6.12%	3.93%

Option 2: Assessment on Total Non-Group and Small Group Markets

Total Premium Base for Non-Group and Small Group (from section b. above)

	2014	2015	2016
Non-group	$ 115,124,123	$ 143,905,154	$ 172,686,185
Small Group	$ 420,490,527	$ 441,515,053	$ 463,590,806
Total	$ 535,614,650	$ 585,420,207	$ 636,276,990

Assessment on NG & SG Necessary to Meet Exchange Operating Expenses

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	3.73%	3.42%	3.14%
Medium	$ 22,500,000	4.20%	3.84%	3.54%
High	$ 25,000,000	4.67%	4.27%	3.93%

Option 3: Assessment on Total Health Insurance Market Similar to Premium Tax (Non-Group + Small Group + Large Group + Medicaid MCO)

Total Premium Base for Health Insurance Market (from section b. above)

	2014	2015	2016
Non-group	$ 115,124,123	$ 143,905,154	$ 172,686,185
Small Group	$ 420,490,527	$ 441,515,053	$ 463,590,806
Large Group	$ 1,681,789,791	$ 1,765,879,281	$ 1,854,173,245
Medicaid MCO	$ 645,682,527	$ 677,966,654	$ 711,864,986
Total	$ 2,863,086,968	$ 3,029,266,141	$ 3,202,315,221

Assessment on Health Insurance Market Necessary to Meet Exchange Operating Expenses

Scenario	Exchange Operating Expenses	2014	2015	2016
Low	$ 20,000,000	0.70%	0.66%	0.62%
Medium	$ 22,500,000	0.79%	0.74%	0.70%
High	$ 25,000,000	0.87%	0.83%	0.78%

Appendix D: Review of Working Group Meetings

The following contains reviews of the DC HBX Financial Sustainability Meetings, which were sent to members prior to the upcoming meeting.

Review of Meeting #1 held on April 17, 2013
Financial Sustainability Working Group

Charge of the Working Group

The working group's charge was discussed at the beginning of the first meeting. The working group is charged with reviewing potential Exchange revenue sources and making a recommendation to the Board as to which source(s) of revenue the Exchange should use to support its operations. The working group's scope does not include defining the exact percentage or dollar figure of an assessment.

Revenue Source Options

Wakely provided working group members with a background report, which included potential sources of revenue for the Exchange. The working group discussed that the revenue sources listed in the report, other sources, and possible combinations of different sources. In addition, the revenue sources of other state-based Exchanges were discussed. Wakely's background report included the following potential revenue sources:

- QHP Enrollment – user fee (or surcharge) on premiums administered through the Exchange
- All Insured Premiums – assessment on insurance premium revenue (individual, small group, and large group markets)
- Health Care Market – assessment on hospital revenue or other provider revenues
- Public Funding Source – e.g. tobacco tax, soda tax, or general tax revenues

Working group members offered two additional potential revenue sources to consider:

- Assessment on employers, including large group employers
- Re-direct an increase in premium tax revenue or DISB assessment due to increases in the total premium base caused by the ACA

Based on feedback from working group members and upon further discussion, the chairs and facilitators of the working group decided to focus the working group's discussion for following meetings on three potential revenue source options:

1. Assessment on Exchange Enrollment Only (user fee)
2. Assessment on Non-group and Small Group Markets
3. Assessment on Health Insurance Market Similar to Premium Tax(Non-group & Small Group & Large Group & Medicaid MCO)

Criteria

The working group also discussed criteria for evaluating potential Exchange revenue sources. Wakley presented example criteria in the background report, and working group members offered additional criteria to consider, which resulted in the following list of criteria.

1. **Exchange Value Relationship** – how closely is the assessment tied to the value the Exchange provides?
2. **Administrative Ease** – how difficult or administratively costly is the revenue model to the Exchange?
3. **Complexity and Variability of Revenue Source** – how stable or predictable is the expected revenue stream? If it is necessary to change or alter the revenue source, what is the process and necessary lead time?
4. **Burden** – does the assessment cause undue burden to small businesses or low income individuals?
5. **Market Impacts** – what incentives or market impacts are caused by the assessment?
6. **Political Feasibility** – how politically or legislatively feasible is the assessment?

Insurance Premium Tax and DISB Assessment

Phillip Barlow from the Department of Insurance, Securities, and Banking (DISB) joined the working group meeting to discuss the Insurance Premium Tax and DISB operational assessment, administered by DISB. Both the tax and assessment were explained with a discussion of general dollar figures associated with each. Below is a brief description of the premium tax and DISB assessment, as discussed during working group meeting.

Insurance Premium Tax

Carriers are required to pay a 2% tax on premiums written in the district. The portion of tax revenues derived from health insurance premiums are allocated to the Department of Health, while revenues from other insurance markets are allocated as general tax revenues. Certain health insurance premiums are not subject to the premium tax, including benefits of federal employees (FEHB).

DISB Assessment

DISB assesses the insurance market to fund the department's operational costs. DISB determines its operational budget for the following year and calculates the percentage fee that will be placed on the premiums written in the district by each carrier. By law the assessment cannot exceed 3/10 of one percent on premiums.

Working group members raised questions related to the premium tax and DISB assessment and asked Wakely to follow up with DISB to perform a more detailed analysis (see "Next Steps" below).

Next Steps

As a result of the first meeting, Wakely was tasked with analyzing potential assessments of various revenue sources and coordinating with DISB to provide further details on the anticipated growth of the premium tax and DISB assessment resulting in 2014 and beyond from the ACA.

Review of Meeting #2 held on April 30, 2013
Financial Sustainability Working Group

Revenue Source Options

Three Exchange revenue source options were presented to the working group with corresponding analysis of assessment rate estimates for each option (see Revenue Source Options Analysis document). The three revenue source options for consideration were:

1. Assessment on Exchange Enrollment Only (user fee)
2. Assessment on Non-group and Small Group Markets
3. Assessment on Health Insurance Market – Similar to the Premium Tax (Non-group & Small Group & Large Group & Medicaid MCO)

As a result of the first meeting there seemed to be broad interest among working group members that the Exchange should pursue a broad assessment. The revenue source options analysis performed by Wakely further supported this stance. A relatively large assessment would need to be placed on the market for options 1 and 2, to support Exchange operations. On the other hand, option 3 assesses a larger base and would require a lower percentage assessment on the market. As the working group discussed the analysis and criteria to evaluate the options, there seemed to be unanimous support that option 3 was the best revenue source, but CareFirst and Kaiser both reserved their opinions.

The working group continued to have discussions on whether the self-insured market could be included in an assessment. Because ERISA prevents self-insured benefits from being taxed, the only means to reach the self-insured market would be to place an assessment on medical claims or on reinsurance. However, the working group agreed that a new provider tax on claims would not be feasible from a political and legislative standpoint. After further discussion to clarify the intent, Wakely was tasked to investigate reinsurance premiums as a source for added assessment.

Retaliatory Tax

CareFirst voiced a concern that option 3 might trigger Retaliatory Taxes from other states. For reference, here is a summary of the District of Columbia's Retaliatory Tax legislation:

§ 47-2610
When a state charges District of Columbia domiciled companies aggregate taxes which exceed the aggregate taxes that the District charges similar companies, retaliation occurs. When a state charges fines, deposits and other obligations in excess of those the District charges foreign insurers, retaliation may occur. This does not apply to personal income taxes, ad valorem taxes on real or personal property, and any special assessments charged by a state in connection with insurance other than property insurance. The District of Columbia does not include fees in the retaliatory tax computation

Source: NAIC State Retaliatory Tax Survey

Additional discussion with an insurer member from the working group indicated that their company is concerned about the Retaliatory Tax. However, they were not certain if this concern was significant enough to cause disapproval for Option 3. Insurer members plan to perform additional analysis and provide the working group with an explanation of Retaliatory Tax concerns.

Including Reinsurance and Stop-loss Premiums in an Assessment

Several working group members were interested in determining whether reinsurance and stop-loss premiums could be included in an assessment. These premiums are currently not included in the Insurance Premium Tax. Wakely has estimated the amount of additional revenue Option 3 would provide, if reinsurance premiums were to be included in the base of health insurance premiums for purposes of the assessment. Assuming that the $2 billion in premium revenue for DC (aside from FEHBP) is matched by another $2 billion in self-insured benefits, and that on average reinsurance premiums are 2% of claims, we have estimated that the revenue generated by Option 3 would increase, as a result of adding reinsurance premiums to the assessment base, by about $235,000 in 2014 and $260,000 in 2016 (@ 0.7% assessment). This increase in revenue represents about 1 % of the estimated operating expenses of the Exchange ($20 – 25 million). As a result of adding reinsurance premiums to the premium base, the necessary assessment for the Low scenario ($20 million) in 2014 would decrease from 0.70% to 0.69%.

The District's practical ability to assess reinsurance premiums is also dubious. DISB believes that there is no means to require stop loss premiums covering DC employers to be written in DC, and that attempting to assess these premiums would simply encourage them to be written outside of the District in order to escape the assessment.

Appendix E: Individual Working Group Members' Submitted Statements

Working group members were invited to submit a brief statement to be included in the report to the Board. The purpose of these statements is to allow members to clarify their position, which may have not been fully captured in the body of the report. Individual statements submitted by members are attached below in the order in which they were received.

Statement #1

(submitted via email on May 8, 2013)

Randolph S. Sergent
Vice President & Deputy General Counsel
CareFirst BlueCross BlueShield

Dear Leighton, Jill, and Jon:

I write on behalf of CareFirst BlueCross BlueShield, and in response to the various proposals for financing the DC Exchange that are before the DC Sustainability Working Group. We believe that this would be a bad time to increase the District's premium tax, or other insurance related taxes or fees, given the significant challenges that DC's employers and consumers already will face in 2014. In our view, the District should fund the Exchange from existing premium taxes and any additional revenue sources that do not result in increased insurance fees to the District's employers and consumers.

The new cost-drivers faced by DC's employers and consumers include the implementation of the new Affordable Care Act mandates and the expected price increases in the individual and group markets that will result from moving to a 'guaranteed issue' market, in which all individuals or groups must be provided coverage, from a medically underwritten market, in which insurance rates were based on the experience of individuals who were healthy enough to pass medical underwriting. The new costs include new federal taxes and fees on insurers and on employers who provide insurance, which will further increase the price of insurance. Consumers and small employers also will experience the dramatic changes to the insurance delivery system that the District is contemplating, and large employers must address new mandates that will require many employers to increase their contributions to employee health coverage, in order to meet federal "affordability" requirements. If the costs are too significant, other large employers may drop coverage altogether and pay a tax penalty. Insured and self-insured employer groups also will face new administrative costs and expenses to implement new ACA requirements imposed directly on those groups.

CareFirst believes that the goals of the ACA are worthy and important, and has partnered with the District and other jurisdictions in implementing the Act. At the same time, however, we are very concerned with the mounting costs of the reforms. In isolation, any one of these new costs, fees, expenses, or rate increases may seem small. The current proposal in "Option 3," for example, would propose a new premium tax of between 0.70% and 0.87% on all insured business in the District. This new tax will be reflected in each carrier's rates and will pass directly to the District's consumers and employers. While the amount of this one tax may seem small, the combination of the premiums, costs, fees, and expenses associated with the ACA will significantly increase insurance costs in all three markets – thereby increasing incentives for employers to drop coverage or to self-insure. The District should not exacerbate this problem with an additional tax increase.

We agree that funding for the Exchange should be broadly based, and that Options 1 and 2, which impose limited, but large assessments on the individual market only (in the case of Option 1) or on the individual and small group insurance markets only (in the case of Option 2), are not viable proposals. Option 3, however, also imposes significant additional costs on DC insurance consumers and employers. In discussing Option 3, Maryland has been identified by some members of the Advisory Group as an example that the District should follow. In Maryland, it is true that the Exchange will be funded from Maryland's premium tax. At the same time, however, the State of Maryland did not increase its premium tax – the tax remains at the same 2% level that was imposed prior to enactment of the ACA. We believe that this is a sound and sensible approach, given the upward price pressures that already exist in this marketplace, because it does not further burden the District's insurance consumers and employers.

According to our research, in 2011, insurers offering health products in the District had gross premium tax liabilities of nearly $47.7 million. That figure does not include additional assessments that health insurers pay to fund certain operations of DISB and DOH. The 2011 gross premium tax is more than double the proposed FY 2014 Exchange budget. Total premiums are expected to grow as a result of the new Exchange market place, which will lead to an increase in revenue under the existing 2% premium tax. Given that fact, and that existing revenue from the current 2% tax on health insurance exceeds the projected cost of Exchange operations, we believe it would be appropriate to use a portion of those revenues to fund the Exchange, without increasing the tax rate.

Finally, we do have continued concerns over potential retaliatory taxes. This analysis would vary for each insurer, depending upon where that insurer is domiciled and the law of the insurer's home state, but is of concern to CareFirst because the two CareFirst carriers that operate in DC, GHMSI and CareFirst BlueChoice, are both DC domestic entities that also sell insurance in Maryland and Virginia, both of which have a retaliatory tax statute. As an example, under Maryland's retaliatory tax statute at Section 6-303 of Maryland's Insurance Article, if DC premium taxes charged to a Maryland carrier, such as Kaiser, exceed the 2% in premium taxes imposed by Maryland, Maryland may increase the premium taxes imposed on DC carriers such as GHMSI and BlueChoice to match the DC rate. An unintended consequence of DC's increase in its premium tax may be that CareFirst will pay more in additional taxes to Maryland than it would owe to DC. We do not believe that this would be efficient, and it would only exacerbate the increased costs of insurance for employers and consumers in the region.

Thank you for the opportunity to comment, and we respectfully ask that the Advisory Group recommend a means of funding the DC exchange that will not increase taxes or fees on health insurance in the District.

--Randy

Additional Statements

After submitting a draft version of this report to working group members for comment, one member suggested a change in language to the recommendation. As mentioned in a footnote on page three of the report, this member felt that a higher level of current health insurance premium taxes could be devoted to the HBX. This member's statement is attached below. Two additional members submitted comments expressing disapproval with the changed language. Their statements are attached as well. The Chairs decided to insert a footnote to the recommendation, citing the suggested change in language and disapproval from members to the changes.

Statement #2

(submitted via email on May 15, 2013)

Randolph S. Sergent
Vice President & Deputy General Counsel
CareFirst BlueCross BlueShield

Thank you for your work for the Work Group. CareFirst's position statement is appended to the report already, so I won't restate here what is said in that statement. We are broadly in agreement with the recommendations stated in the Report, with one small exception. In the specific recommendations on page three, we believe that the first recommendation should not be limited only to determining whether there would be "unanticipated collections" – that should be part of the analysis, but we also believe that the best approach would be to dedicate a portion of the existing premium tax to the DC Exchange even if that cost were not wholly offset by new or unanticipated collections. The reasons for our position are set out in my earlier e-mail. I believe that this was also the position of some of the other members of the committee.

With that in mind, we suggest revising the first recommendation on page 3 of the draft report to make clear (1) that, if the premium tax is the source of funding, a portion of the tax should be dedicated to the exchange, so that it could be financially self sustaining, and (2) that the analysis of whether this is feasible is not limited just to reviewing "unanticipated collections." Here are the specific revisions that we propose:

1. HBX staff should, in consultation with other District officials, seek dedicated funding for the Exchange Authority ~~determine if there will be unanticipated collections~~ from the existing health insurance premium tax and assessments, including consideration of any new or unanticipated collections, such that a dedicated amount from these existing taxes will ~~that can~~ be used to support the Exchange Authority and permit the Authority to ~~and that this is consistent with the legislative requirement that the Authority~~ be "financially self-sustaining."

With that modification, such that this recommendation is not limited only to consideration of unanticipated collections, we support the Work Group's recommendation. Thanks again, and please feel free to contact me if you have any questions.

--Randy

Statement #3

(submitted via email on May 16, 2013)

Dave Chandra
Senior Policy Analyst
Center on Budget and Policy Priorities

I personally would not feel comfortable accepting the amendment. I think the consensus position reached reflected that people supported; at least it did for me. I do not support broadening the language to include the language of "existing premium tax revenue" because that is essentially the same as requesting general fund contributions to support exchange operations. In addition to being a request almost never considered by states building exchanges, my understanding from my colleagues who are working on securing adequate funding for existing health and human service programs is that there simply isn't any amount of general fund revenue lying around to be reallocated for this. I believe the existing statement best reflects my positions and so would not be inclined to support an amendment.

If the group felt they wanted to revisit it, I would request we follow the establish process which likely would include scheduling a new call to debate the issue and vote again (not sure there is appetite for that!)

Statement #4

(submitted via email on May 16, 2013)

Wes Rivers
DC Fiscal Policy Institute

All,

I concur with Dave, DC Fiscal Policy Institute would not support the language as amended. The charge of the group was to find a "self-sustaining" financing mechanism for the District Exchange, and I think using existing premium revenue already dedicated to other programs violates that charge. I also think that this point was debated in our call and our original consensus recommendation reflected a compromise that took that debate into account. DCFPI advocates for initiatives that are currently funded or partially funded through the existing premium revenue, including Healthy DC initiatives and the DC Healthcare Alliance, and we will not support language that may put spending pressures on those programs or have the Exchange compete for those funds.

Thanks,
Wes